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ABSTRACT

The legislative history of the formula-grant program is surveyed. Testimony at congressional hearings is examined to ascertain the positions of government and health professions organizations regarding the purposes and use of formula grants over time. It is shown how changes in the successive laws reflect changing goals of the program. The actual uses of the funds and the relationship between purposes and accomplishments are studied with focus on dental schools only. Two trends are noted: (1) Schools and professional organizations have regarded the funds as subsidies to existing programs rather than as incentives to increase enrollment, and (2) in each renewal of the legislation, Congress has attempted to create stronger incentives to increasing enrollments and graduates and to make more explicit its intentions that the number of health professionals increase. It is also noted that the first-year enrollment increases in medical and dental schools between 1965-1971 were approximately equal to the number of federally-funded new school spaces built in that period, indicating minimal enrollment increases coming from the formula-grant program alone. This is concluded to raise the question: Can per-student grants to schools be effective to increase enrollments without also giving the schools substantial construction assistance? (LBH)

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# LEGISLATIVE HISTORY OF THE FEDERAL FORMULA-GRANT PROGRAM UNDER THE HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE ACT 1965-1971

by Owen MacBride

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## LEGISLATIVE HISTORY OF THE FEDERAL FORMULA-GRANT PROGRAM

### I. INTRODUCTION

As was seen in the paper "An Overview of the Health Professions Educational Assistance Act" (MacBride, 1973), medical, dental, and other health professions schools have been receiving federal financial aid by a formula based on enrollments and graduates since 1966. From 1966 to 1971 these grants were called "basic improvement" or "institutional" grants; in the present legislation, they are called "capitation" grants. Currently, there is great interest in both the proper purpose of these grants and the proper means of setting the amount and making the awards. In fact, these topics are the subject of a $2 million federally financed study being conducted by the National Academy of Sciences.

This paper will survey the legislative history of the formula-grant program. Testimony at congressional hearings will be examined to ascertain the positions of government and health professions organizations regarding the purposes and uses of formula grants over time. An attempt will be made to show how changes in the successive laws reflect changing goals of the program. Finally, focusing on the dental schools only, the actual uses of the funds and the relationship between purposes and accomplishments will be examined.

This paper will, therefore, attempt to identify the goals and intentions of some of the groups involved in passage and operation of the formula-grant program. However, a word of caution is in order

in this respect. When a large body, such as the House of Representatives, passes a measure, its members act from varying motives, and it is difficult to peg a "collective intent" based on the body's passage of that particular measure. When a large organization such as the A.A.M.C. "supports" a measure, it is even more tenuous to say that the words of its spokespersons accurately indicate the intentions of its members. Thus, the purposes of the various congressmen who voted for health manpower legislation may not be the same as the intentions of congressmen who drafted and sponsored the bill; and the goals and intentions of the heads of health professions schools which receive the financial support, may not conform to the representations made by their professional organizations.

Nevertheless, two trends will be apparent. First, since it was obviously the "purpose" of the original health professions educational assistance program (P.L. 88-129, 1963) to increase the number of health professionals,[1] it can be assumed that Congress "intended" the formula-grant program to be directed at least in part toward this goal. However, the schools and the professional organizations have regarded the funds as subsidies to existing programs rather than as incentives to increase enrollment. This has been shown both in their testimony before passage of legislation and in their use of funds after passage. Second, in each renewal of the legislation, Congress has therefore attempted to create stronger incentives to increasing enrollments and graduates and to make more explicit its intentions that the number of health professionals increase.

The testimony will indicate that formula-type funds have been used to "upgrade" existing programs. Yet, since H.P.E.A. began in 1963, sizeable increases in enrollments at health professions schools can be observed. These are probably mainly due to the H.P.E.A. construction program, which also carries enrollment increase requirements. In order to evaluate the effectiveness of the formula-grant part of the program in increasing enrollments, therefore, one would have to determine how much of the increase in enrollments came from construction of new capacity, and how much came from expansion of programs without building new capacity. Preliminary indications seem to be that the first-year enrollment increases in medical and dental schools between 1965-1971 were approximately equal to the number of federally-funded new school spaces built in that period, thus indicating minimal enrollment increases coming from the formula-grant program alone. /For further discussion, see "An Overview of the Health Professions' Education Assistance Act," Part V (MacBride, 1973)./ This raises the question: Can per-student grants to schools be effective to increase enrollments in those schools without also giving the schools substantial construction assistance?

II. LEGISLATIVE HISTORY

A. Health Professions Educational Assistance Amendments of 1965

The Health Professions Educational Assistance Program initially provided federal funds to schools for construction and student financial aid only. The original 1963 bill, P.L. 88-129, did not provide for any formula-type assistance.

In 1965 amendments to the program were proposed which included formula-type assistance under the title "basic improvement grants." Under this proposal, each health professions school qualifying was to receive $12,500 plus $250 per full-time student in the fiscal year 1965-1966; and $25,000 plus $500 per full-time student in each of the succeeding four years of the program.

In testimony before House and Senate committees considering the legislation, several opinions were expressed as to the purpose and use of the basic improvement grants. Representatives of the Administration apparently felt that the grant would both subsidize operating costs for financially hard-pressed schools, and lead to increased enrollments. Edward W. Dempsey, Special Assistant (Health and Medical Affairs) to the Secretary of HEW testified that the grants (a) would relieve the financial stringencies on "poorer" schools which were having trouble meeting operating costs, and (b) would be a direct incentive to schools to increase enrollment.[2]

Testifying in another hearing, Dr. Dempsey stated:

> We believe particularly that the basic and special improvement grants will go far toward stabilizing these schools which are presently in grave financial difficulty . . . . We risk the absolute bankruptcy of a few of the schools we have. These basic special and improvement grants are designed to meet that difficulty . . . .
>
> The basic improvement grant would have the effect of relieving the financial stringencies of the poorer schools. It would provide a larger proportion of the budget of these poorer schools than it would of the budgets of schools more adequately endowed. It would directly reward any school that increased its enrollment.[3]

Appearing with Dr. Dempsey, Dr. Wilbur J. Cohen, Under Secretary of HEW, stated that the purpose of the grants was to strengthen the

financial and academic positions of the weaker health professions schools.[4]

Representatives of the various health professions schools and organizations also emphasized that the basic improvement grants were needed to alleviate financial difficulties and improve the quality of existing academic programs. Dr. Robert C. Berson, Executive Director of the Association of American Medical Colleges, divided the member institutions into three categories by financial status. He stated that the formula grants would enable "weak" schools to continue to provide education of acceptable quality; would enable "well-off" schools to continue to pioneer in new program areas; and would enable the majority of schools, those in a "middle" financial position, to keep current programs going, correct weaknesses, institute new programs of known value, and expand enrollments.[5] Spokespersons for the American Association of Dental Schools stated that the grants would prevent "underfinanced" dental schools from "dropping out" or suffering substandard educational quality;[6] and that the major need for the federal funds (in dental schools) was to use in improving student/faculty ratios.[7]

There was uniform opposition among witnesses to attaching an enrollment increase requirement to the basic improvement grants. (Under the proposed requirement a school receiving basic improvement funds would have to give "adequate assurances" that it would increase enrollment in each program year by 2.5 percent over its highest enrollment during 1960-1965, or by five students, whichever was greater.) Dempsey and Cohen of HEW, who had both said the grant program would

provide rewards and incentives for schools to increase enrollments, were both opposed to requiring schools to increase enrollment in order to receive these funds. Dr. Cohen felt that the enrollment increase requirement would result in a lowering of the quality of education in weaker schools.[8] Dr. Dempsey stated that attempting to expand enrollment would only exacerbate the financial difficulties of the health professions schools.[9] In a later letter to the Senate Committee on Labor and Public Welfare, Dr. Cohen expanded on the Administration's objection to the enrollment increase requirement:

> We view this House amendment, therefore, as seriously limiting the extent to which the basic and special improvement grants would help achieve the purpose of strengthening the capability of these health professional schools to provide high-quality training for their students. We recommend the deletion of this amendment.[16]

The Bureau of the Budget also expressed this Administration view: "We believe it is especially important at this time that no effort be made to require an increase in the number of medical students for schools to qualify for basic improvement grants."[17]

The professional organizations all opposed the enrollment increase requirement. Among the representatives and groups who testified against this requirement were:

--Dr. Edward C. Rosenow, Jr., Executive Director, American College of Physicians;[10]

--Dr. George A. Wolf, President, Association of American Medical Colleges;[11]

--Dr. Robert C. Berson, Executive Director, Association of American Medical Colleges, who qualified his objections by stating

that the requirement should be waived for (1) financially weak schools, and (2) schools which recently increased their enrollments to the "limit;"[12]

--Dr. Maynard K. Hine, President-Elect, American Dental Association, who stated:

> The associations believe that this amendment (the enrollment increase requirement) runs counter to the objective of improving the quality of medical and dental education--clearly the result will be to diminish rather than to enhance the level of education presently offered . . . it is clear that the amendment is incompatible with the avowed purpose of the basic and special improvement grants.[13]

--The American Association of Dental Schools: "There is now a demonstrable need for substantial financial support to improve the quality of existing enrollment" (emphasis added).[14]

--Dr. Henry W. Hofstetter, American Optometric Association, who said, "It would seem that this section of the bill (the enrollment increase requirement) runs counter to the objective of health education aid."[15]

Even the House and Senate committee reports on the proposed legislation emphasized the basic improvement grants as subsidies to existing programs. The House report stated that the basic and special improvement grants would provide increased financial support to schools "in order to aid them in increasing the scope and quality of their teaching programs and to redress the present imbalance at these institutions arising out of emphasis on research programs.[18] It continued:

> The basic improvement grant would have the effect of relieving the financial stringencies of the poorer schools.

> It would provide a larger proportion of the budget of these poorer schools than it would of the budgets of schools more adequately endowed. Inadequately endowed schools can be expected to use these funds chiefly for improving their most critical weaknesses in the basic components of professional education. Through use of these funds poorer schools would accomplish such things as: Improving student-faculty ratio, attracting more highly-qualified faculty, and strengthening and enriching basic curriculum . . . .
>
> More adequately supported schools would also shore up basic weaknesses. In addition, schools would use these grants for such things as achieving balance in curriculum areas and experimenting with innovations in professional health education . . . .
>
> Medical and dental schools are in dire need of operating funds just to maintain basic educational programs for their undergraduate students.[19]

The committee noted that the Administration had proposed awarding a grant to a school if the school gave reasonable promise of "strengthening and improving the faculty and curriculum of the applicant school." However, despite this, despite the testimony of representatives from the Administration and from the health professions, and despite its own comments on the purpose and uses of the basic improvement grants, the Committee decided that the following tests for receiving funds should be used: (1) whether the recipient school would give "adequate assurances" of increased enrollment in the proposed amount; (2) whether the school would give "adequate assurances" that it would continue to expend as much non-federal money as it had (on the average) over the previous three fiscal years. (Such a requirement would insure that federal funds would supplement the schools' other sources of income, not supplant those other sources). Despite insisting on the enrollment increase requirement, the Committee made the following somewhat conflicting statement: "It is,

therefore, the purpose of the program of basic improvement grants . . . to provide means whereby (health professions) schools . . . can improve their strength and programs and thereby provide better training of health professions personnel to meet the needs of the future."[20]

The Report of the Senate Committee on Labor and Public Welfare similarly stressed the subsidy-to-existing-programs functions of the basic improvement grants. The Committee emphasized the need of medical and dental schools for support of operating funds to avoid "financial disaster," and stated that the grants would "provide increased support in order to aid them in increasing the scope and quality of their teaching programs."[21]

Despite all these objections, the bill was passed as proposed, including the enrollment increase requirement for basic improvement funding. However, a provision was included which allowed the granting authorities to waive the enrollment increase requirement if it appeared that the increase could be achieved only at the expense of a reduction in the quality of education at the school.

Inclusion of the enrollment increase requirement must be interpreted as showing a Congressional "intent" that the basic improvement funds be used (at least in part) to produce additional health manpower. It is apparent, however, from the testimony of those who were to administer the program (HEW) and those who were to receive and make final spending decisions on the money (the health professions schools), that these groups wanted to use the funds to stave off financial disaster, or to maintain or improve the quality of existing education programs. Increasing

enrollment was seen as a secondary goal by these groups.

Two questions should, therefore, be kept in mind in analyzing the 1965 and later formula-grant legislation. First, was the amount of the per school and per student grants ($25,000 and $50) really a sufficient incentive to the schools to increase enrollment? In other words, would these funds cover the additional costs which schools would face from increased enrollments? Second, how many schools, receiving basic improvement funds had the enrollment increase requirement waived by the granting authorities? These questions will be discussed fully later.

B. Health Manpower Act of 1968.

The proposed Health Manpower Act of 1968, S. 3095, altered the method of awarding basic improvement grants (now called "institutional grants") somewhat away from a size formula. Under the new system, each health professions school with an approved application was to receive a flat $25,000. Any funds remaining of the appropriations for that fiscal year after all qualifying schools received their $25,000 was to be distributed among those schools on the basis of relative increases in enrollments and graduates, and relative numbers of full-time students, under a formula by which a school would receive twice as much credit for a "new" student (representing increased enrollment) as for other students. A similar enrollment increase requirement as that used in P.L. 89-290 was also proposed (but using an updated base, 1963-1968 instead of 1960-1965).

Reviewing the 1964 program several Congressional committee witnesses observed that basic improvement funds had been used primarily for "upgrading" purposes and to alleviate financial distress. Dr. Philip R. Lee

of HEW stated

> With basic improvement grants funds, schools are improving and expanding their educational capabilities. The majority of the funds are being used for support of teaching faculty. With these grants, schools are developing new courses, improving teaching methods (including use of visual aids), expanding curriculum areas, improving library resources, and otherwise supporting and strengthening their teaching programs . . . . Schools of medicine and osteopathy have strengthened and expanded both basic science courses and clinical instruction and are experimenting with innovations in education.[22]

Dr. Charles A. McCallum of the A.A.D.S. testified that dental schools had used basic improvement funds to add new courses, obtain new educational equipment, and hire more faculty.[23]

The House Committee on Interstate and Foreign Commerce, in its report on the proposed legislation, also noted this use of the basic improvement funds by schools. The committee report used almost the same language as had been used by Dr. Lee of HEW.[24]

Health professions organizations continued to stress the need for subsidy-type funds and to oppose strict enrollment increase requirements. The American Medical Association objected to tying institutional grants to enrollment increases, because many of the schools needed the funds just to stay open and maintain current activities.[25]

William N. Hubbard, representing the A.A.M.C., stated that for schools to make significant enrollment increases, the institutional grants would have to be increased to cover a "reasonable portion of the educational costs of the institutions." (Hubbard said that the proposed improvement grants, even if fully funded, would cover only about ten percent of educational costs.) Hubbard further advocated that institutional support be provided for the "entire range" of functions of the academic medical

center. The A.A.M.C. did, however, agree with the change in the granting formula so as to recognize the number of graduates as well as of students, "since, actually, the public welfare is best served by graduates."[26]

Dr. F. Darl Ostrander, American Dental Association President, stated that the dental school's biggest need for funds was to use in increasing the number of faculty.[27] And Charles W. Bliven, of the American Association of Colleges of Pharmacy, testified that, "One of our needs now is for grants which can be used by the schools to strengthen their total programs."[28]

The Administration now favored both the enrollment increase requirement and a requirement that a school could receive no more federal funds than the amount of its non-federal expenditures for teaching purposes during the preceding year.[29] This latter requirement can be viewed in two ways: first, as representing an intention that federal funds supplement but not supplant existing sources of income to the health professions schools; second, as an incentive to the schools to search for more non-federal revenues (since by increasing its non-federal revenues, a school could presumably raise the top limit on its federal institutional grant in the following year). However, the Administration opposed use of a rigid enrollment increase requirement. Their spokesperson, Dr. Lee, told the House Committee on Interstate and Foreign Commerce:

> Experience under the expansion of enrollment requirement of the present law has demonstrated that the purposes of the health professions educational assistance program cannot be fully achieved with a rigid and inflexible enforcement of this requirement.[30]

Dr. Lee also told the Senate Subcommittee on Health that rigid application

of the enrollment increase requirement was resulting in lower educational standards at some schools.[31]

Both the Administration and the House Committee on Interstate and Foreign Commerce felt that the new formula for awarding institutional funds would provide greater incentives to the health professions schools to increase enrollments than had the 1963 law. Dr. Lee pointed out that the proposed law was worded so as to reward increases in enrollments and graduates, not just absolute sizes of enrollments.[32] The House Committee's report stated that under the proposed formula, "The increased funding for increased enrollment will encourage the schools to enlarge their enrollment while at the same time helping them with the cost of educating additional students." The Committee observed that, by rewarding increases in graduates, the new formula was also intended to provide incentives for schools to decrease training periods (without decreasing quality of output, of course) and develop means for accepting students with advanced standing.[33]

The proposed law was adopted essentially without change (Public Law 90-490). The enrollment increase requirement remained at 2.5 percent (of the highest enrollment between 1963-1968), or five students, whichever was greater, in each year a school received funds. The provision was also included which limited a school to receiving no more formula grant funds than the amount of non-federally financed expenditures for teaching purposes in the previous year. As Dr. Lee and the House Committee on Interstate and Foreign Commerce had observed, the criteria for awarding funds now (theoretically at least) provided greater incentives for increasing enrollments. However, it is not clear how powerful these incentives were,

in view of two factors: (1) a school could receive $25,000 per year just for meeting the minimum increase, and the per-extra-student grant beyond this may have been less than the cost of adding another student; (2) all of the $25,000 grants were to be disbursed to qualifying schools before "formula" monies were awarded, thus creating the risk that the appropriations for the institutional grants could be exhausted before "per student" awards were made.*

C. Comprehensive Health Manpower Training Act of 1971.

The term "capitation grant" was first used in the proposed H.P.E.A. legislation for 1971, to describe the "per student" institutional support grants. As was summarized in the paper "An Overview of the Health Professions Educational Assistance Act" (MacBride, 1973), the amount of institutional support a health professions school would receive now depended on several factors: the type of school (capitation rates were set at different amounts for the different types of schools), the different types of students, and the numbers of students, graduates, and "increased" enrollments.

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*Congressman William Cahill had an interesting proposal with regard to the criteria for granting federal money. Cahill was concerned that medical schools would not like the enrollment increase requirements and so would attempt to finance as much of their operations as possible with federal research funds. He thus proposed, " . . . an effort to tie the N.I.H. and other research grants to medical schools to a formula which will require increased enrollment as a condition precedent to receiving federal research assistance . . . institutional research grants should be granted to medical schools (rather than to "principal chief investigators") and should be allocated on the basis of formula which would give a weighted priority to those schools undertaking enrollment expansion."[34]

The report of the Senate Committee on Labor and Public Welfare on the proposed legislation is particularly interesting because it contains several clear statements of the purposes of the legislation. (While this report dealt specifically with S. 934, a bill that was defeated, S. 934 was very similar to the bill which eventually passed, H.R. 3629. The bills were comparable structurally but differed primarily in the levels at which capitation payments were set). First, the report contains a statement of the two-fold broad purpose of the legislation in general and the capitation program in particular:

> The bill is aimed at increasing the supply of health professions personnel . . . while stabilizing the finances of health professions educational institutions . . . (the capitation) award is intended to stabilize the institutions' financial status while offering incentives for increased enrollment and shortened curricula."[35]

The committee expressed a philosophy that if health professions schools were adequately financed, they would be willing and able to increase class sizes:

> These institutions can and will respond to these (national health) needs only if they are assured of a predictable amount of federal funds sufficient to stabilize their finances . . . . The bill therefore entitles each educational institution to an award intended to cover approximately one-third* of the average per student educational costs incurred nationally by such institutions if the institution makes a reasonable effort to respond to the national need by increasing enrollments, reducing the time period required for the completion of study and making other efforts to increase the supply of health services personnel and by improving and expanding education

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*S. 934 proposed capitation payments of $4,000 per M.D.-, O.D.-, or D.D.S.-student, and $6,000 per graduate. The final amounts passed in H.R. 3629 were somewhat lower; $2,500 per first-, second-, and third-year student and $4,000 per graduating fourth-year student.

> programs . . . . The committee intends by this breakdown of capitation payments (by all enrollees, enrollees in expanded entering classes, and enrollees completing a shortened curriculum) to provide incentives to institutions to respond to national need while providing assurances of basic support to schools making a reasonable effort."[36]

The "maintenance of effort" requirement for federal funding had been revived by S. 934's authors. They proposed that each school be required to provide assurances that it would expend, in carrying out its function as a school, an amount of non-federal funds equal to its average expenditures in this respect over the three previous fiscal years. Commenting on this proposal, the Committee stated that "the bill also assures that these institutions may not supplant non-federal funds with federal funds. The Committee intends to assume that these institutions maintain a wide variety of sources of financial support."[37]

Because of dissatisfaction that institutional grants had been used in the past largely to "bail out" financially distressed schools, the proposed legislation contained a separate section on "financial distress" aid, to insure that capitation grants would not be used for this purpose. The Committee commented:

> Accordingly, the Committee has substantially increased the authorization for institutional or capitation entitlement grants while removing the authority for financial distress grant support from the special project authority. The committee has separately authorized a diminishing financial distress program."[38]

Finally, the Committee emphasized its goal that the supply of health professionals would increase through this program: "The Committee wishes to make clear its general intent that in the future schools would increase enrollments from year to year or at least would not reduce enrollments in any particular future year."[39]

There were two areas of disagreement as to how per-unit support should be awarded: (1) whether the grant should be based on school size (enrollments) or output (graduates); (2) the amount of the capitation grant. Regarding the first disagreement, the Administration favored a formula based on number of graduates rather than number of students. Secretary of Health, Education, and Welfare, Elliot Richardson, testified to the House Subcommittee on Public Health and Environment that a capitation grant rewarding output, rather than subsidizing the size of enrollment, would encourage the maximum feasible production of doctors and dentists (the Administration had proposed $6,000 per graduate and had not proposed any enrollment increase requirements).[40] However, the method proposed by the new bills was to base the grants either on enrollment or on a combination of enrollment and graduates.

Regarding the second disagreement, those due to receive the capitation money were naturally anxious to have the per student amount be as high as possible. Representatives of the A.A.M.C. backed their requests for higher capitation amounts with claims that the annual per-student cost of education in medical schools was $15,000-$25,000. However, this group also conceded that the Carnegie Commission had called for a $4,000 per student capitation.[41] During the Congressional hearings, the capitation was debated in the range of $2,000-$6,000.

As the Committee on Labor and Public Welfare report showed, the formula grant was being openly acknowledged as a subsidy to medical school operating costs, as well as an incentive to increase enrollment. However, it is not clear whether the capitation amount was being related to the

"true" cost of education. The Committee on Labor and Public Welfare said that it was;[42] but Secretary Richardson testified that the Administration's proposed $6,000 per graduate was not intended to be a "cost-of-education" price, but rather, when multiplied by the number of graduates, a reasonable federal share of funds provided to schools to help them stablize finances. The $6,000 figure was arrived at in full consideration of the other sources of support available to medical schools.[43] Anylan of the A.A.M.C. said that the purpose of the grants should be to provide a "predictable level of substantial support for basic operating purposes."[44]

More insights into the purpose of the capitation grant can be gained from the Committee on Interstate and Foreign Commerce report on the bill (H.R. 8629), which was finally passed as the Comprehensive Health Manpower Training Act. That report said in part:

> (Health Professions) schools must have dependable and continuing resources of sufficient magnitude to permit realistic planning for meeting their educational responsibilities. A capitation grant would mean that a school could anticipate how much federal money it could count on for support of its educational program. It would allow an institution to make its own plans as to how it could best use the monies . . . .[46]
>
> The capitation levels proposed in this bill are designed to significantly alleviate the financial distress of those schools which are in serious financial straits. Grants should enhance the ability of schools more fortunately situated to increase enrollments and make their curricula increasingly relevant to the health care needs of the Nation. The capitation grants are designed to provide a dependable support base for the educational programs of the health professions schools without having to go through the "backdoor" of research to support education.[46]

However, the Committee did express a strong intention that the program lead to increased production of health professionals:

> The $4,000 for each graduate is designed to provide incentives for increasing and accelerating production of physicians and dentists (as well as effecting increased financial stability in the institution) . . . . The committee feels strongly that if schools are to receive assistance of the magnitude proposed in this bill there should be results--There should be increased manpower.[47]

As finally passed, the Comprehensive Health Manpower Training Act of 1971 (Public Law 92-157) provided much more clearly-defined programs and specific incentives than had its predecessors. The provisions of the law pertaining to formula grants, which were more complicated than the provisions in the 1965 and 1968 laws, have been discussed in detail in the paper, "An Overview of the Health Professions Educational Assistance Act" (MacBride, 1973). However, the main points will be summarized again here.

The amount of the capitation varied by type of health professions school. Medical, dental, and osteopathic schools received the highest grants: $2,500 per first-, second-, or third-year students, and $4,000 per graduating senior. An incentive was provided to decrease the training time necessary to produce physicians: three-year schools of medicine received $2,500 per student (all classes) plus $6,000 per graduating third-year student.*

An incentive to increasing enrollment (in addition to the basic $2,500 per student) was also included. A school would receive an additional $1,000 for each student who represented an increase in the school's enrollment

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*Thus, a four-year school could receive a maximum of $11,500 per physician produced, over four years, while a three-year school could receive a maximum of $13,500 over three years.

above the required amount, up to a maximum "extra" grant of $150,000 per year. However, this went with a new, larger enrollment increase requirement. In order to receive capitation funds, a school was now required to provide assurances that it would increase its enrollment in the next year by (a) ten percent over its 1970-1971 enrollment, if that was less than 100, or (b) five percent over 1970-1971 enrollment, or ten students (which ever was greater) if 1970-1971 enrollment exceeded 100. This requirement could again be waived if the Secretary of HEW felt such enrollment increases could not be effected without a reduction in quality of education.

Both the "maintenance of effort" requirement and the separate "financial distress" grants, discussed above, were incorporated in P.L. 92-157. Finally, any school which had not received federal funds before June 30, 1971 was required, when applying thereafter for capitation money, to present a "plan" for using the funds in one of several areas. An example of such a plan, given in the text of P.L. 92-157, was "a project to effect significant improvements in the curriculum of such schools."*

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*Other possibilities included plans to establish cooperative interdisciplinary training, train new types of personnel, make innovative changes in existing programs, conduct projects to increase the supply of health professionals, do training in certain specified areas, increase "minority" or "disadvantaged" enrollment, or conduct training in family medicine.

NOTES

[1]See for example the various testimony in U.S. Congress, House, Committee on Interstate and Foreign Commerce. Hearings on H.R. 4999, 8774, 8833. January 1962. Washington, D.C., Government Printing Office, 1962; and U.S. Congress, Senate, Committee on Labor and Public Welfare, Subcommittee on Health. Hearings on S. 911 and H.R. 12. August 22-26, 1963. Washington, D.C., Government Printing Office, 1963.

[2]U.S. Congress, House, Committee on Interstate and Foreign Commerce, Subcommittee on Public Health and Welfare. Health Professions Educational Amendments of 1965: Hearings on H.R. 2366, 3141, 6000, 7385, 7806, 8751, 8805, 8811. 89th Congress, First Session, June 8-9, 1965. Washington, D.C., Government Printing Office, 1965. Statement of Edward W. Dempsey, Special Assistant to the Secretary (Health and Medical Affairs), Department of Health, Education, and Welfare, p. 43.

[3]U.S. Congress, Senate, Committee on Labor and Public Welfare, Subcommittee on Health. Health Professions Educational Assistance: Hearings on S. 595 and H.R. 3141. 89th Congress, First Session, September 8, 1965. Washington, D.C., Government Printing Office, 1965. Testimony of Dr. Edward W. Dempsey, Acting Assistant Secretary, Health and Medical Affairs, Department of Health, Education, and Welfare.

[4]Ibid., Statement of Wilbur J. Cohen, Under Secretary, Department of Health, Education, and Welfare, p. 36.

[5]Ibid., Statement of Dr. Robert C. Berson, Executive Director, Association of American Medical Colleges, p. 68. This testimony was essentially duplicated in House Committee on Interstate and Foreign Commerce. Hearings (1965), op. cit., p.

[6]Senate Committee on Labor and Public Welfare, Hearings (1965), op. cit. Statement of the American Association of Dental Schools, p. 81.

[7]House Committee on Interstate and Foreign Commerce, Hearings (1965), op. cit. Statement of the American Association of Dental Schools, p. 99.

[8]Senate Committee on Labor and Public Welfare, Hearings (1965), op. cit. Statement of Wilbur J. Cohen, Under Secretary, Department of Health, Education, and Welfare, p. 36.

[9]Ibid., Testimony of Dr. Edward W. Dempsey, Acting Assistant Secretary, Health and Medical Affairs, Department of Health, Education, and Welfare.

[10]Ibid., Statement of Dr. Edward C. Rosenow, Jr., Executive Director, American College of Physicians, p. 59.

[11]Ibid., Statement of Dr. George A. Wolf, President, Association of American Medical Colleges, p. 62.

[12]Ibid., Statement of Dr. Robert C. Berson, Executive Director, Association of American Medical Colleges, p. 68.

[13]Ibid., Statement of Dr. Maynard K. Hine, President-Elect, American Dental Association, p. 73.

[14]Ibid., Statement of the American Association of Dental Schools, p. 81.

[15]Ibid., Statement of Dr. Henry W. Hofstetter, American Optometric Association, p. 124.

[16]U.S. Congress, Senate, Committee on Labor and Public Welfare. Health Professions Educational Assistance Amendments of 1965: Report on H.R. 3141. 89th Congress, 1st Session, Senate Report No. 89-789, September 28, 1965. Washington, D.C., Government Printing Office, 1965. Letter from Wilbur J. Cohen, Under Secretary, Department of Health, Education, and Welfare, p. 26.

[17]Ibid., Letter from Phillip S. Hughes, Assistant Director for Legislative Reference, Bureau of the Budget, p. 15.

[18]U.S. Congress, House, Committee on Interstate and Foreign Commerce, Health Professions Educational Assistance Amendments of 1965: Report on H.R. 3141. 89th Congress, 1st Session, House Report No. 89-[illegible], August 12, 1965. Washington, D.C., Government Printing Office, 1965. p. 2.

[19]Ibid., pp. 15-16.

[20]Ibid., pp. 18-19.

[21]Senate Committee on Labor and Public Welfare, Report on H.R. 3141, op. cit., pp. 1, 5.

[22]U.S. Congress, House, Committee on Interstate and Foreign Commerce, Subcommittee on Public Health and Welfare. Health Manpower Act of 1968: Hearings on H.R. 15757. 90th Congress, 2nd Session, June 11-13, 1968. Washington, D.C., Government Printing Office, 1968. Statement of Dr. Philip R. Lee, Assistant Secretary for Health and Scientific Affairs, Department of Health, Education, and Welfare, p. 19.

[23]U.S. Congress, Senate, Committee on Labor and Public Welfare, Subcommittee on Health. Health Manpower Act of 1968: Hearings on S. 3095 and S. 255. 90th Congress, 2nd Session, March 20-21, 1968. Washington, D.C., Government Printing Office, 1968. Statement of Dr. Charles A. McCallum, Jr., Vice President, American Association of Dental Schools, p. 205.

[24]U.S. Congress, House, Committee on Interstate and Foreign Commerce. Health Manpower Act of 1968: Report on H.R. 15757. 90th Congress, 2nd Session, House Report No. 90-1634, July 3, 1968. Washington, D.C., Government Printing Office, 1968. p. 19.

[25]House Committee on Interstate and Foreign Commerce, Hearings (1968), op. cit. Statement of Dr. William A. Sodeman, member of the Executive Committee on Medical Education, American Medical Association; Accompanied by Dr. C. H. William Puhe, Director, Division of Medical Education; and Harry N. Peterson, Atty., Legislative Department, A.M.A., p. 95. Dr. Sodeman made similar testimony in the Senate Committee on Labor and Public Welfare hearings. See page 220.

[26]Senate Committee on Labor and Public Welfare, Hearings (1968), op. cit. Statement of Dr. William N. Hubbard, Past President, Association of American Medical Colleges, p. 102.

[27]House Committee on Interstate and Foreign Commerce, Hearings (1968), op. cit. Statement of Dr. F. Darl Ostrander, President, American Dental Association, p. 154.

[28]Senate Committee on Labor and Public Welfare, Hearings (1968), op. cit. Statement of Charles W. Bliven, Executive Secretary, American Association of Colleges of Pharmacy, p. 240.

[29]House Committee on Interstate and Foreign Commerce, Hearings (1968), op. cit. Statement of Dr. Philip R. Lee, Assistant Secretary for Health and Scientific Affairs, Department of Health, Education, and Welfare, p. 19.

[30]Ibid.

[31]Senate Committee on Labor and Public Welfare, op. cit. Statement of Dr. Philip R. Lee, Assistant Secretary for Health and Scientific Affairs, Department of Health, Education, and Welfare, p. 46.

[32]House Committee on Interstate and Foreign Commerce, Hearings (1968), op. cit. Statement of Dr. Philip R. Lee, Assistant Secretary for Health and Scientific Affairs, Department of Health, Education, and Welfare, p. 19.

[33]House Committee on Interstate and Foreign Commerce, Report (1968), op. cit., p. 30

[34]House Committee on Interstate and Foreign Commerce, Hearings (1968), op. cit. Statement of Hon. William T. Cahill, A Representative in Congress from the State of New Jersey, p. 110.

[35]U.S. Congress, Senate, Committee on Labor and Public Welfare, Health Professions Educational Assistance Amendments of 1971: Report on S. 934. 92nd Congress, 1st, Session, Senate Report No. 92-251, July 12, 1971. Washington, D.C., Government Printing Office, 1971. p. 2.

[36]Ibid., pp. 16-17.

[37]Ibid., p. 17.

[38]Ibid., p. 10.

[39]Ibid., p. 19.

[40]U.S. Congress, House, Committee on Interstate and Foreign Commerce, Subcommittee on Public Health and Environment. Health Professions Educational Assistance Amendments of 1971: Hearings on H.R. 703, 4171, et. al. 92nd Congress, 1st Session. April 2-29, 1971. Washington, D.C., Government Printing Office, 1971. Statement of Hon. Elliot L. Richardson, Secretary, Department of Health, Education, and Welfare, p. 447.

[41]Ibid., Statement of William G. Anylan, Chairman, Executive Council, Association of American Medical Colleges, p. 537.

[42]Senate Committee on Labor and Public Welfare, Report (1971), p. 16.

[43]House Committee on Interstate and Foreign Commerce, Hearings (1971), op. cit. Statement of Hon. Elliot L. Richardson, Secretary, Department of Health, Education, and Welfare, p. 447.

[44]Ibid., Statement of William G. Anylan, Chairman, Executive Council, Association of American Medical Colleges, p. 537.

[45]U.S. Congress, House, Committee on Interstate and Foreign Commerce. Comprehensive Health Manpower Training Act of 1971: Report on H.R. 8629. 92nd Congress, 1st Session. Washington, D.C. Government Printing Office, 1971. p. 27.

[46]Ibid., p. 28.

[47]Ibid.